

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$1,751.00 for dates of service, commencing on 6-11-01 and extending through 7-13-02.
- b. The request was received on 5-15-03.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA(s)
 - c. EOB/TWCC 62 forms/Medical Audit summary
 - d. Medical Records
 - e. Example EOBs from other Carriers
 - f. Study of Billing Rates, Program Elements, and Cost of CARF Accredited Chronic Pain Management Programs in Texas in the Year 2000
 - g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. HCFA(s)
 - c. Medical Audit summary/EOB/TWCC 62 form
 - d. Information Regarding Chronic Pain Management
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07-24-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07-25-02. The Requestor submitted additional information that was received by the Commission on 7-25-02. A copy was forwarded to the insurance carrier on 7-31-02. The carrier representative signed for the copy on 8-01-02. The response from the insurance carrier was received in the Division on 8-01-02. The insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 7-17-02

"...Numerous attempts have been made to collect the outstanding balance on this account, with telephone calls, and reconsideration letters. Reconsiderations have been previously submitted to TWCC under separate cover. (Carrier) has set a rate of \$115.00 for Chronic Pain Management reimbursement. We are submitting herewith redacted Explanation of Benefits from four (4) insurance carriers supporting our rate of \$128/hour as Fair [sic] and reasonable. We seek full reimbursement for the outstanding balance of \$1751.00, along with interest accrued according to rule 134.803...."

2. Respondent: Letter dated 8-07-02

"...This dispute concerns billing for chronic pain management under CPT code 97799. Provider has sought medical dispute resolution for dates of service 6/2/01 to 7/13/01.... Self insured's position is that the bill has been paid at a fair and reasonable rate, in accordance with TWCC Medical Fee Guidelines, Commission policy, and the Texas Labor Code.... Therefore, chronic pain management is to be reimbursed at a fair and reasonable rate.... Therefore, each carrier must determine a level of fair and reasonable reimbursement. Provider has billed its services at a rate of \$128.00 per hour. Self-insured has made payment based on determination of a fair and reasonable reimbursement from a third party audit. (Audit Company) conducted the audit for the self-insured. (Audit Company) determined that \$115.00 per hour is the appropriate reimbursement level for CARF accredited programs and that \$92.00 per hour is the appropriate reimbursement level for non-CARF programs. (Audit Company) reached this calculation in cooperation with (provider), the provider in this case. (Audit Company's) documentation regarding this process is attached as Exhibit A [sic] (Director of Support Services) of (provider) has stated in an affidavit that its billing rate for chronic pain management is \$115.00 under CPT code 97799. The affidavit also shows that this level of payment was accepted by (provider) as appropriate payment from 61 different insurance carriers. A copy of this documentation is attached as Exhibit B.... Provider has not documented that it is entitled to reimbursement at a level higher than [sic] \$115.00...."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 6-11-01 and extending through 7-13-01.
2. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$20,096.00 for services rendered on the dates of service in dispute above.

3. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$18,345.00 for services rendered on the dates of service in dispute above.
4. The Carrier denied payment for dates of service commencing on 6-11-01 and extending through 7-13-01 as "M – NO MAR SET BY TWCC-REDUCED TO FAIR AND REASONABLE".
5. The amount in dispute is \$1,751.00 for services rendered on the dates of service in dispute above.
6. According to HCFAs submitted, the provider is a CARF accredited facility. Therefore, the 20% reduction does not apply, per MFG, MGR (II) (C).

V. RATIONALE

Medical Review Division's rationale:

The Requestor has billed CPT code 97799-CP-AP, which is a DOP (no MAR) per the MFG. The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes... HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Medical documentation submitted indicates these charges are for a chronic pain program. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. The Requestor has submitted additional reimbursement data, which is four example EOBs for charges billed for similar services. However, only two were utilized. Also submitted was a study of billing rates, program elements, and cost of care accredited chronic pain management programs in Texas in the year 2000. Included are affidavits from various CARF accredited chronic pain management programs throughout the state. Based on the data obtained, the usual and customary rates for CARF accredited facilities vary from \$115.00 to \$175.00 per hour.

The Carrier's response was timely but did not include a methodology. Per rule 133.304 (i) "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the Carrier shall include, per Rule 133.307 (j) (1) (F), “.... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;”. The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor has provided some documentation to support their position that the amount billed is fair and reasonable. Again, the Carrier’s response did not include a methodology. The injured worker attended 16 sessions at 8 hours, 4 sessions at 6 hours and 1 session at 5 hours for a total of 157 hours. The Requestor’s Table of Disputed Services indicates they billed \$20,096.00. Carrier reimbursed the Requestor \$18,345.00. Additional reimbursement of **\$1,751.00** ($\$128.00 \times 157 \text{ hours billed} = \$20,096.00 - \$18,345.00 \text{ carrier payment} = \$1,751.00$) is recommended.

The above Findings and Decision are hereby issued this 06th day of March 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$1,751.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 06th day of March 2003.

Carolyn Ollar
Supervisor - Medical Dispute Resolution Officer
Medical Review Division

CO/pd